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ABSTRACT

This publication contains conference presentations given by five nurses who have interpreted the philosophy of the role of the professional nurse at the Clinical Center, the research hospital of the National Institutes of Health. Included in the presentations are discussion of methods utilized within the Nursing Department by which professional nurses may progress to levels of increasing responsibility for: (1) influencing the quality of nursing care to the patient and nursing support of clinical research, and (2) making an impact upon the nursing community. Presentations were: (1) "The Philosophy of the Nursing Department" by Louise C. Anderson, (2) "Professional Responsibilities as Interpreted by the Staff Nurse" by Elizabeth Conley, (3) "Professional Responsibilities as Interpreted by the Clinical Nurse Expert" by Barbara Rolling, (4) "The Role of an In-House Consultant in a Nursing Service" by June McCalla, and (5) "Coordinating Professional Competencies on the Nursing Unit" by Maureen Regan. (SB)

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Professional Progression in the Nursing Department

A Nursing Clinical Conference
presented by
the Nursing Department
of the
Clinical Center
National Institutes of Health

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Introduction

Nursing Clinical Conferences are an important part of the continuing education program at the Clinical Center, the research hospital of the National Institutes of Health.

During the year, each of the eight Nursing Services conducts a conference to describe significant nursing care cases and procedures. Speakers at this conference, however, represent positions rather than nursing services. Conferences enable members of the Clinical Center's nursing staff to keep informed of many research studies and to study a wide range of nursing care problems. The edited proceedings of these conferences are now being published so they may be useful to a wide audience.

LOUISE C. ANDERSON, R.N., M. Ed.
Chief, Nursing Department
The Clinical Center

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PROFESSIONAL PROGRESSION IN THE NURSING DEPARTMENT

LOUISE C. ANDERSON, R.N., M.Ed.
Chief, Nursing Department

The Philosophy of the Nursing Department

To accomplish something one must know the goal or goals toward which he is directing his energies. The squirrel on a wheel can expend considerable energy to no purpose as can an employee who finds little or no satisfaction in his work situation.

Our general belief in the Clinical Center Nursing Department is that every position within the department is vital to patient welfare and to the research endeavor. Failure on the part of any employee to meet his or her commitment can have a disastrous effect upon the patient and the total work situation, as well as effect harmful habit patterns for himself.

For these reasons, it is the administrative position that every employee should know exactly what his job requires in the way of background preparation, performance, attitude, and reliability in order to find his particular niche in the department. All endeavor in the direction of patient well-being is based upon cooperative effort which implies in itself an understanding of mutual dependence and mutual respect of coworkers. Any person attempting to achieve something indefinable, nebulous, or vague will inevitably become discouraged, frustrated, and fatigued. On the other hand, most of us work hard and long in a situation where the job to be accomplished is well defined and of obvious merit. It is the responsibility of the administration to define the job to be done honestly, clearly, and specifically. It is the responsibility of the employee, having accepted the job, to do it to the best of his ability, in conformance with the established policies of employment and with full knowledge of what that job contributes to the whole.

As a basic assumption the foregoing is true, but those of us responsible for management of nursing services and patient welfare believe that this in itself is not enough. The rapidity of change in today's society brings home the fact that a dynamic program of learning, analysis, suggestion and evaluation is a part of any program that aims to survive,

and so in setting our goals for the Nursing Department we tried to be as broad as a research agency requires, as realistic in relation to possible accomplishment as we could be, and as generous in our sharing as our facilities permit.

Our long-range goals are:

1) To provide the best nursing care possible with the staff available to patients undergoing investigative medical study

2) To develop all personnel to the fullest extent of their capabilities and the professional nurse as a truly professional person

3) To share with the community those aspects of the nursing program which will be beneficial to them and which will enhance the stature of nursing in the community.

Each year the Nursing Administrative Council reviews the short-range goals of the previous year to assess the degree to which they have contributed to accomplishment toward the long-range goals and establishes the program for the coming year. In order to arrive at an attainable program that is geared to the needs of patients first and then employees, all categories of personnel are asked to give careful consideration to suggestions for the total program and submit them through their representative advisory committees to the Nursing Administrative Council. The Council then is better able to review, sift, and evaluate the suggestions which finally lead to the proposed goals for the year ahead. The goals, having been established, are then reviewed with all categories of personnel with time for questions and answers.

It is the administrative belief that all employees should have the opportunity to provide in a systematic way the crystallization of ideas they have toward improved patient care brought about by cooperative effort on the part of all members of the Nursing Department. Whether or not each employee participates is a decision he or she must make, but the opportunity is there and we have been gratified by the positive attitude of the majority of members who consistently demonstrate a true interest in patient welfare and an understanding of the purpose of research.

This background summary leads us to today's discussion, which, for lack of time, is concerned with only one aspect of the second long-range goal—the development of the nurse as a truly professional person. Because the development of the professional nurse as a role model for the patient, other nurses, subprofessional health groups, and the public is important to the achievement of national health goals we have endeavored to develop at the Clinical Center a defined progression up the professional ladder. The defined endeavor is young in years—less than seven—and there have been many difficulties and many disappointments, but we have made progress and a purely subjective consensus is that patients have profited and we have, in part, achieved an understanding on the part of the professional nurse staff of the direction in which we are going. No person who works solely for payment of services without regard for the influence he has on others or the impression he creates for associates, or who fails to recognize the responsibility he has for positive contributions to society can come close to the designation "professional." One of our assumptions in designing the professional staff development program is that the majority of nurses are interested in being the truly professional nurse, the professional nurse who is desperately needed to exert leadership in the development of auxiliary

groups made up of persons who can be trained and molded into the variety of health technicians that will be needed in great quantities in the years ahead.

That professional person sees that his attitude, appearance, and performance make the total profession what it is in the eyes of the community at large. There is the unwritten obligation to keep current with the rapidly increasing knowledge of new treatments, new procedures, new systems; to cooperate with other professions in making our nation a healthier nation, both physically and mentally; to be the citizen that professionalism implies by serving in whatever position one finds oneself to the very best of the inherent ability enhanced by specific educational experiences.

Our ladder of professional progression begins with the staff nurse who is the pivotal figure for quality nursing care, the clinical nurse expert whose independence of function and decision is based on the recognition of professional responsibility and integrity, and the clinical nurse consultant. The clinical nurse consultant moves into a consultant position because of her continuing accumulation of knowledge in a specialty and her interest in applying that knowledge to complex situations after acquiring a maturity of purpose and action demonstrated by superior interest in and care of the patient with a diversity of problems. The head nurse serves as coordinator of nursing activities and research procedures on the clinical research unit. She responds to both clinical and administrative demands which make her role difficult but challenging.

ELIZABETH CONLEY, R.N., B.S.
Clinical Nurse, Heart Nursing Service

Professional Responsibilities as Interpreted by the Staff Nurse

Nursing is not a profession! This has been the assertion of critics both within and without nursing in the past and at the present time. What nursing will be in the future is largely dependent on what we as individual nurses accomplish now.

I take issue with those who argue that nursing is not a profession for I firmly believe that it is indeed very much a profession. Quoting Abraham Flexner's criteria for professions, I would like to share with you how I see nursing as meeting these requirements and the present responsibilities of the staff nurse in strengthening the image of nursing in the future.

Professions involve essentially intellectual operations accompanied by large undivided responsibility.

Certainly nursing requires minute by minute the exercise of judgment and the making of sound decisions. Patients' welfare and even lives depend on the critical observations of the nurse, how she analyzes and evaluates these observations, and her resulting actions. Surely this is responsibility! The reduction in incidences of complications and in length of patient stay is critically dependent on the amount and type of nursing care.

Each nurse must accept herself as an individual and as a nurse capable of making contributions both alone and as part of a group. She must be able to make up her own mind as to what is best for her patients and be true to herself and her convictions regardless of the cost.

In addition to being aware of her assets, the nurse must also be aware of her weaknesses. No one can be all-wise and all-knowing, especially now in this age of ever increasing complexity and specialization. Thus she must face up to this and be able and willing to seek assistance when in doubt.

They are learned in nature and their members are constantly resorting to the laboratory and seminar for a fresh supply of facts.

As students and registered nurses, we are always in the laboratory of the hospital setting. Only here can we learn the techniques, practices, and skills so essential to our work with patients.

We can increase our knowledge in a number of ways. Some nurses choose advanced formal education. For others this is not always possible. However, we have many other opportunities available

to us for acquiring new knowledge. Often we gain more understanding through reading a patient's chart, attending in-service programs and conferences, and asking a question of another nurse, doctor, or paramedical person regarding something we do not understand. Much can be learned through the sharing of ideas and knowledge with others.

It behooves all of us to keep abreast of new developments in nursing care and current and changing methods of care through reading of the nursing journals and new nursing texts in the library.

They are not merely academic and theoretical, however, but are definitely practical in the aims.

The nurse uses her academic and theoretical knowledge to aid the recovery of her patients and their families. The staff nurse assesses each individual patient as a member of society and as a personality in a culture in order to determine his physical, emotional, spiritual, economic, social, and rehabilitative needs. This must be done with respect for every person regardless of race, creed, color, physical or mental condition, or social or economic status. She then formulates a nursing care plan with the best possible approaches for this patient and his family. Is this not practicality?

Virginia Henderson describes this so well when she says:

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or recovery (or to peaceful death), that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible." [2]

It seems that nowadays the nurse frequently finds herself becoming farther removed from the bedside. Thus it behooves her to exercise the delegation of tasks to appropriate persons in order to spend as much time as feasible with the patient.

Frequently, too, the staff nurse finds herself caught up in the carousel of too many tasks to accomplish in a given time. Thus she must determine what is of utmost importance and learn to set priorities for herself and to help her team members to do likewise.

They possess a technique capable of communication through a highly specialized educational discipline.

Nursing education is the acquisition of knowledge, skills, and the process of critical and analytical thinking.

Thelma Pelley describes this process in the following manner:

"It prepares a person to give a greater service with the vision that sees beyond the limitations of the circumscribed task to be performed. Education supplies the knowledge, the tools, and the skills which enable a person to seek and to attain for himself, and to help others to seek and attain, a wholeness of body, mind, and spirit, despite many discouragements and seeming failures. Education is that which gives understanding as well as knowledge and produces a spirit of deep and humble compassion so that the educated nurse will serve with a song in the heart, a confident reassuring smile upon the face, the light of understanding and concern in the eye, and the undergirding, uplifting strength of gentleness in the touch of the hand." [3]

Surely this nursing discipline is a lofty ideal and a never-ending endeavor throughout one's nursing career.

They are self-organized, with activities, duties and responsibilities which completely engage their participants and develop group consciousness.

A professional group constantly strives to maintain and improve the services it provides through organized efforts. We are striving toward this end here at the Clinical Center through the Staff Nurse Advisory Committee. We are attempting to increase group awareness and improve our nursing practices by learning to function through organized channels. We are learning to communicate better with ourselves and with those in administration in an effort to develop an atmosphere of mutual trust, respect, and understanding. To accomplish this, the support and cooperation of each staff nurse is required.

Another way group consciousness can be appreciated by the staff nurse is through attendance at district association meetings, support of these leaders and their efforts, and participation in the activities of the group.

They are likely to be more responsible to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievements of social ends.

A profession comes into being to fulfill a need which society cannot perform for itself. We in nursing, by our examples and our teaching, are called upon to help others preserve health and prevent disease. All of us should willingly accept this challenge as a vital part of improving the health of the world.

The quality of our patient care will largely determine what we can expect from society. Thelma Pelley says that ". . . . when nurses demonstrate in practice the unmistakable qualities of professional service, then society will voluntarily and spontaneously accord nursing its due, honor, and prestige. Professional status can be earned only by the quality of practice; it cannot be acquired by self-seeking." [3]

What then will be the future of nursing? Shall we drift along in the present and allow another group or discipline to decide the course for nursing? Or shall we rise to the occasion and claim our full professional status? The final results depend on each staff nurse willingly accepting her responsibilities.

For myself, I have found much gratification in bedside nursing and I see the staff nurse as the key figure in patient recovery. We are just beginning to overcome our inferiority complexes and it seems to me that we need to stand tall together in our profession in working for top quality nursing care for patients.

BARBARA ROLLING, R.N., M.A.
Clinical Nurse Expert
Eye Nursing Service

Professional Responsibilities as Interpreted by the Clinical Nurse Expert

The role of the clinical nurse expert was created at the Clinical Center in 1965 when some supervisory positions were eliminated to provide for assignment of clinical nurse experts who would give and guide direct patient care. It was felt that some supervisors could be used better in the role of an expert, and that they themselves would be happier in this role. It was also felt that teaching by example probably held the greatest potential for the results desired—better patient care.

Clinical nurse experts would:

1. Work with the most difficult patients in the actual situations, analyzing their needs, establishing problem-solving approaches to major problems, and interpreting the established nursing care principles to all nursing personnel on the unit.
2. Be available for full-time activity with physicians who are developing protocols for new research activities and who need nursing assistance to establish these protocols.
3. Work with new staff members who are not familiar with Clinical Center nursing policies and procedures and who need to have nursing standards interpreted for them by concrete example.

More than six years have elapsed since the creation of this position, and there are presently twelve clinical nurse experts. Even though there is a broad framework under which they all function, the role varies from one nursing service to another. Realistically speaking, the demands of an acutely-ill unit are much different from those of a slower-paced unit. And the demands of an established service are quite readily different from the demands of a new service. For instance, on the Heart Nursing Service, the ability of the clinical nurse expert is directed toward developing the staff nurse's expertise in the care of an acutely-ill patient, in a life-and-death situation. On the Cancer Nursing Service, she may be responsible for the supervision and development of the staff member assigned to the Laminar Flow Room.

There are certain commonalities attributable to all twelve clinical nurse experts: They are not bound by hours nor hospital geography in the discharge of their professional responsibilities. They

are dedicated and committed to the task at hand. They function on the unit under the head nurse. They exercise independent thought in planning a program for staff development. They are flexible in a changing nursing role. They develop a good working relationship with the staff and with the physicians. They are available to provide advice and counsel to any nursing service requiring knowledge of their specialization. As their main objective, they serve as a "facilitator" or "enabler" in providing the best possible patient care.

In talking about the clinical nurse expert within a nursing service, I can best speak from my own experience in a new nursing service. In September of 1970, a selected group of professional nurses formed the Eye Nursing Service. This group was composed of staff nurses who had been on 13 West (ophthalmology) for some time, and those newly assigned to the unit. Several avenues for staff development were available in the specialized field of eye nursing. For instance, staff nurses attended daily physicians' rounds at which time the patients and future planning for the patients were discussed. In order to gain knowledge of ophthalmology weekly grand rounds were attended by the staff nurses.

The clinical nurse expert had a responsibility in the development of in-service education programs. Personnel of outside agencies in related fields, such as the Eye Bank, the Prevention of Blindness Society, and the Columbia Lighthouse for the Blind, were invited to talk to the staff nurses. Our physicians participated in the teaching-learning situation by discussing their area of special interest. Staff nurses had opportunities to observe eye surgery. With a view toward understanding the emotional needs of the visually impaired patient, Mrs. Yvonne Burton, clinical nurse, and I initiated weekly staff nurse conferences with the head nurse, chaplain, and social worker. (Psychological support of the patient is imperative on the Eye Nursing Service.)

In March, 1971, a remodeled Eye Clinic was opened for outpatient care. It was the responsibility of the clinical nurse expert to write up the procedures and protocols, and to develop the clinic into a well-organized, functioning one. It is a rapidly expanding clinic and provides a setting for the staff nurse from the Eye Nursing Service to assist the physician with patient care, and to learn about the intricate workings of ophthalmological equipment.

Recently one of the physicians and I planned a research study which will include an expanded role for the staff nurse. It will be my responsibility to become involved with each new research activity, and in turn teach the staff nurse the required nursing procedure.

A clinical nurse expert on a new service has a challenging role. Within five years she will be astonished at the many changes that will have occurred since the service was first established. She will have much to do with developing the professional nurse skills that will add so much to the welfare of the patient.

In conclusion, the clinical nurse expert has a responsibility for developing other professional nurses in the direction of clinical nursing expertise while at the same time continuing her own professional growth. This entails a concerted effort to keep herself and others current with new concepts in the area of specialization. Reading the literature, attending lectures, and participating in workshops—all these are pathways for development. The clinical nurse expert's sincere desire to continue learning about

her own clinical specialty and to further develop her own and others' nursing skills in a sense gives the staff added zest for what they are doing and realization of the importance of their efforts. The clinical nurse expert has a responsibility to share through her professional organization. Her experience at the Clinical Center can give her a wealth of in-depth knowledge to contribute to the nursing literature. This would enable other nurses in other hospitals to share her nursing knowledge and experience.

Lastly, it is her responsibility to see that the staff nurse does not reach a plateau, to assure that the staff nurse is encouraged to set her goals in professional progression, and to find ways to expand and develop her potential for giving quality nursing care.

In my 1½ years as a clinical nurse expert, I feel that I have benefited most from the opportunity to exhibit initiative and independent thought. I have also benefited from the physician-nurse "teamwork" which has been instrumental in expanding the nurse's role in the care of the visually impaired patient. It is an important role in the ladder of professional growth.

JUNE McCALLA, R.N., M.S.N.
Pediatric Nurse Consultant

The Role of an In-House Consultant in a Nursing Service

As the pediatric nursing consultant, I am assigned to the Office of the Chief, Clinical Center Nursing Department. Requests for my assistance with a pediatric patient or problem may come from any of the nursing services in the Clinical Center or from a particular medical service in one of the various institutes. Once these written referrals have been accepted by the Office of the Chief, Nursing Department, I am free to set my own priorities as to the need for my services. My activities have included giving direct patient care, solving problems, conducting in-service education, assisting with medical research, acting as a role model, and coordinating the activities of others. Today it is possible to discuss only a few of these activities.

Most of the requests for assistance have originated from the special problems which are created when pediatric patients participate in research projects. Dr. Charles Lowe, Scientific Director of Intramural Research for the National Institute of Child Health and Human Development, has enumerated the reasons why it is important to study children's drugs and treatments of children.[4] He emphasizes that children are not miniature adults but have their own rate-limiting metabolic cycles. Dr. Lowe has described the seven specific periods of childhood during which these metabolic cycles occur and has stressed the importance of determining the special metabolic factors in each cycle. Since drug dosages and treatments would necessarily be unique in each of these periods, it is essential that any new drugs or treatments which could possibly conquer a lethal disease be administered to representatives of each of these age groups.

Case Study

To illustrate some of the difficulties which can arise in pediatric research, and to demonstrate the role of the nurse consultant, I would like to present the medical and nursing history of Bobby T.

Bobby was nine months old when he was admitted to the Immunological Service of the National Cancer Institute. His diagnosis was Swiss type of lymphopenid agammaglobulinemia and the purpose of his admission was to prepare him for a thymus gland transplant. The disease is characterized by a sex-linked genetic recessive transmission to males only. There is a severe clinical course of recurrent infections, marked deficiencies in the immunity system, severe lymphopenia, marked hypoplasia of the lym-

phoreticular system, and a characteristically small or absent thymus gland. The onset of the illness usually occurs in the first week of life and the course is usually fatal because these children lack the ability to produce circulating antibodies and have a deficiency of all immunoglobulins. Several infants with this diagnosis have had their immunological competency restored after a thymus transplant which was followed by a bone marrow transplant.

Bobby's brother was only eight months old when he died of the same disease at Johns Hopkins Hospital. His father had a heart condition and was employed only part time. Mrs. T. described herself as a frustrated nurse. She had had a tubal ligation after Bobby's birth. The family had many relatives but there was much family friction and little emotional support.

At the time of Bobby's admission, the medical staff planned to prepare him for the transplant of a foetal thymus which could be obtained only from England. Since the baby was underdeveloped, had been chronically ill, and had little or no resistance to infection, he was immediately placed in Reverse Isolation and remained so isolated for his entire hospital stay. It was necessary for all who entered his room to wear gown, mask, cap and sometimes gloves as well. He was, therefore, deprived of many of his sensory experiences. From his first to his twenty-second hospital day, the baby was plagued with various chest, skin, and blood infections. In the beginning the mother could feed her child and participate in his daily care, but as his condition deteriorated she was no longer able to do so. It soon became necessary for him to spend the majority of his time in a croupette. When he developed signs of renal toxicity, frequent blood chemistry samples and continuous urine collections became necessary. As his body was frequently in a state of metabolic imbalance, the baby often had diarrhea stools. His skin soon became easily excoriated.

On his twenty-second hospital day he developed bilateral pneumonia which promptly resulted in a bilateral pneumothorax. He was placed on a respirator, chest tubes were inserted, and arterial and venous cutdowns were performed. His room was filled with equipment. His care now focused on maintaining his survival until the thymus gland arrived.

Bobby had received continuous nursing care for most of his hospital stay and Mrs. T. had always appeared to accept any professional nurse. Now, however, she demonstrated her increasing anxiety by becoming suspicious of all unfamiliar hospital personnel. She would question the nurse repeatedly as she watched her give the baby's care. She scrutinized nurses, housekeeping staff members, and medical consultants and was quick to notice the slightest break in reverse isolation technique. Sometimes she would immediately point out these technique breaks to the staff member concerned; at other times she would report to the head nurse or pediatrician. Bobby's pediatrician had cared for him since early infancy and was known and trusted by his parents. Mrs. T. herself rigidly adhered to all aspects of the reverse isolation technique and criticized those who did not do so even during emergency procedures. It was at this point that I received a request for assistance with Bobby's nursing care.

After several conferences with the head nurse, nursing staff members and the baby's pediatrician, it was decided that I would be introduced to the mother as the pediatric clinical nurse

expert, and that I would then give the baby the majority of his direct nursing care on one tour of duty. Since Mrs. T. spent almost all of her time in the baby's room, we also decided that we would give the change of shift reports in her presence. We wanted her to hear exactly what was said. We also began to ask her help with simple procedures. For example, all urine collection bags were discontinued and weighed diapers were substituted. Mrs. T. helped us weigh and label clean diapers. We also encouraged her to touch, handle, and hold the baby whenever possible.

On his twenty-fourth hospital day, Bobby received his long-awaited thymus transplant. He was taken to the operating room and portions of a fifteen week foetal thymus were inserted into five rectus muscle pockets. The procedure was well tolerated, but he continued to have blood chemistry abnormalities which were soon complicated by a decreased urinary output. A new bilateral pneumonia was found to be fungal in origin, and as the lung disease progressed the baby developed a right-sided heart failure. The baby's condition continued to deteriorate in spite of all therapeutic measures; it soon became obvious that the thymus transplant alone had failed to repair the baby's immune deficiency. The medical staff, therefore, decided to attempt to repopulate the infant's bone marrow with compatible donor stem cells which should provide a self-perpetuating supply of circulating formed blood elements able to fight infection.

An informed consent was obtained from the baby's parents and the various blood typing studies of the family members were completed. There was not a compatible family member donor so it was decided to attempt to reconstitute the baby's marrow with maternal bone marrow. Since Mrs. T.'s blood was blood group O, Rh positive and Bobby's blood was A, Rh positive, the physicians decided to give him an exchange transfusion of blood group O, Rh positive blood. The baby's physical condition was extremely poor so it was necessary to proceed with caution. The decision to use Mrs. T. as the donor for Bobby's bone marrow transplant obviously pleased her. Ever since his admission, Mrs. T. had spent almost all of her waking hours in his room and she would frequently spend the night in the nursing unit solarium. Since it was necessary for Mrs. T. to be hospitalized in order to donate bone marrow, Mrs. T. stayed with Bobby during her forty-eight hour hospitalization.

To accomplish the transplant, a central venous catheter was placed in the infant's right inferior vena cava and he received a four unit exchange transfusion; the fourth unit was of irradiated maternal blood. This was followed by an intravenous infusion of maternal bone marrow. Both procedures were well tolerated.

The baby's physical condition did not improve, however. His kidney complications progressed, the fungal pneumonia failed to respond to therapy, and his cardiac status worsened. During this perioid, when a nurse and Mrs. T. were alone in the baby's room, Mrs. T. frequently ventilated her feelings about the transplant procedures, Bobby's diagnosis, and his medical history. She expressed her feelings of loneliness since the members of her husband's family often voiced their beliefs that these research procedures should never have been performed.

At such a time, a clinician who is familiar with some of the current litera-

ture can often assist a parent who expresses these self-doubts. McCollum and Schwartz,[5] and Lewis, McCollum, Schwartz and Grunt[6] have examined the meaning to parents of the hospitalization of their children in a research center. These authors have noted that the idea of declining hospitalization seemed to be so guilt-laden, and the children were viewed as so endangered by their disease diagnosis, that no alternative sources of medical care were considered available. These investigators have also stated that the risk of research procedures with no guarantee of gain causes anxiety in both parent and child.

The authors all agree, however, that if the parent had adequate time to assimilate the information about the research procedure, if he considered the risks involved, and if he had considered alternative sources of medical care, he should accept without guilt his decision to proceed with the research procedures.

Mrs. T. often reviewed with us the history of her first son's illness and compared it to Bobby's illness. She commented that although she had separated herself from the other mothers on the nursing unit, these mothers approached her offering coffee, food, or just a sympathetic ear when Bobby became so ill. She acknowledged that only these other mothers could understand her self-questioning as to whether she had made the right decision when she permitted the transplant procedures to be performed. Mrs. T. now also spoke of the close relationships she had established with members of the medical and nursing staff.

The nursing care of this infant was a challenge to everyone. When I received the request for assistance, I certainly did not arrive at his bedside with solutions to his nursing care problems. Throughout these difficult days frequent planning sessions were held with the head nurse, pediatrician, and members of the nursing staff. Numerous nursing team conferences focused on Bobby. It was also necessary for me to give direct nursing care to the infant in order to obtain a true picture of the situation. Problem-solving methods were then utilized in order to allay some of Mrs. T.'s anxiety. In other words, what was the best method of proving to Mrs. T. that all of the baby's nurses were competent? We did succeed in restoring Mrs. T.'s confidence in the nursing staff, but this was accomplished by group effort, patience, and tact.

As the pediatric clinical nurse expert, I provided direct patient care on a daily basis until the infant's demise. I also instructed new nurses in the correct procedures for his care. Assistance with medical research was provided during the post-thymus transplant period, during the exchange transfusion, and during and after the bone marrow transplant.

All nurses who cared for Bobby profited from this experience. We have presented the nursing care of Bobby at two in-service education programs. We believe that while his transplantation procedures did not succeed in reconstituting his immune deficiency, caring for Bobby each day added to our professional growth and made better nurses of us all.

MAUREEN REGAN, R.N.
Head Nurse, Cancer Nursing Service

Coordinating Professional Competences on the Nursing Unit

Nursing is changing. It is in a state of turmoil. Our methods are being challenged, but the principles upon which nursing is based remain constant. I think the true feeling, the dedication which makes one a nurse, perhaps can be expressed as one author states: ". . . the true virtue, the true calling of the nurse, consists neither in following doctor's orders nor in administering prescribed treatments (although she ought to do both conscientiously) but in the true aspects contained in the very name of the profession: to nurse and to nurture, to feed the body and to nurture the soul." [7] The author acknowledges the necessity of carrying out the physician's plan of care but recognizes that the utmost value of nursing is what a nurse can do for an individual when she comes to know him as a person.[8]

"Nursing has long been recognized as an art. An art is a body of practical knowledge which tells how to work to produce certain results. An art does not involve any understanding of why things come out as the [illegible]." [9] This definition of nursing in itself is not complete. We have seen the development of nursing as a science. "A science is a body of knowledge based on a large number of carefully collected facts which have been arranged and classified in such a way as to establish certain laws and principles."[9] Nursing requires a broad education and a good understanding of human nature. We must be able to understand and adjust to other people.

The professional nurse initiates and controls nursing care which augments and complements the physician's plan of care. As a head nurse, I feel I have the obligation to help my staff grow as professional people. The head nurse must be a catalyst, planner, coordinator, and evaluator. As a catalyst, I must be able to stimulate those working with me. I have a great opportunity on my unit to be an integral part of the continuous development of the professional nurse.

Orientation

Twelve West is the primary unit used for the orientation of the new clinical nurse to the Clinical Center. In participating in the orientation, certain factors must be considered: (1) understanding of the learning process is essential and the ability to apply this understanding in identifying and meeting the learning needs of the nursing staff is important;

(2) nurses coming to NIH have a variety of educational preparation and experience and therefore require individualized orientations; (3) nurses in the orientation period have a great need for learning and they must be assisted to help them recognize their strengths and weaknesses.[10] We aim at assisting the employee to practice nursing safely and competently and help her develop her potential to the maximum.

We make every effort to provide the new clinical nurse with a variety of experiences. Initially, after her orientation to the physical layout of the unit, she is given a patient assignment for perhaps two consecutive days so she may become familiar with her patients and their needs, with an emphasis on the importance of continuity of care. One at a time the new clinical nurses are oriented to the medication policies and procedures at NIH. They are closely supervised in the administration of medications and questions are encouraged. Since 12 West is primarily a chemotherapy unit, many medications used are totally unfamiliar to most new employees. Drug-Fact Sheets containing basic information about these drugs are made familiar to them. Index cards with the common side-effects are also available.

As the new nurse progresses in her familiarity with the unit, the patients, their medications, and their needs, she is given the opportunity to be team leader for as many days as time allows. She is given experience in transcribing physician's orders and seeing to it that what is ordered is communicated to the staff and executed. Again, realizing that nurses come to us with a variety of experience, varied educational preparation, and specific expectations, each nurse is treated as an individual and we try to meet her specific needs—be it more concentration on medication accuracy, patient care and procedures, managing the nursing team, etc.

As a planner, I work with the research physicians in the early stages of planning clinical research protocols. I am responsible for interpreting to them any problems which might occur for nursing services arising from the research design. It is also necessary to interpret to the nursing staff what the protocol involves and what their responsibilities will be as they relate to the clinical research projects.[11]

As a coordinator, I must coordinate the unit's operations with other Clinical Center departments, medical officers and investigators, and with organizations and individuals outside the hospital.[11] I attempt to hold weekly multidiscipline conferences on the unit involving the entire team: nursing staff, clinical nurse expert, social worker, dietitian, chaplain, physician, and, if indicated, the physical or occupational therapist. I feel that much has been gained by the staff through these conferences. They realize that they are an integral part of the research team. They learn that their observations and contributions are important and essential toward helping us meet our primary goal: providing the best patient care possible.

Utilization of the Clinical Nurse Expert is frequent on my unit. She is an excellent resource person, assisting in the development of new techniques. She plans a nursing care program to fit the total needs of particular patients and then implements this plan herself. She is responsible for orientation of the new nursing staff, interpreting the research aspects of patient care as well as the standards of nursing care as established by the Clinical Center.

NIH provides an excellent learning

climate and I feel it is part of my responsibility as head nurse to see to it that the staff are cognizant of what is available to them; inservice education programs are continuous and attendance is encouraged. I try to provide on-the-unit development of nursing judgment, skills, and techniques. Members of the staff need to know how they are functioning in varying situations. They should be concerned with their growth and development in attaining their full potential. At NIH, nursing personnel are regularly given written evaluations which are fully discussed with them; strengths and weaknesses are reviewed; recommendations are made. It is hoped that these evaluations, along with the day-to-day observations of those involved, will help them to grow as individuals and as professional nurses. The evaluations will also help give them some insight into their own needs and therefore assist them in interpreting the emotional needs of the patients in order to facilitate the emotional adjustment of patients to a new environment, to the new and detailed techniques, and to understand the concept of research.

I see my job as a big one and an important one and I feel that I can best serve the patient by analyzing and then utilizing the many talents brought to my ward by differing personalities, so that a competent, cooperative group evolves into a productive whole with two aims—quality patient care and good support to research.

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Summary

We have heard how four representative professional nurses have interpreted the philosophy of the role of the professional nurse at the Clinical Center. They have described some of their efforts to make those concepts of professionalism operational in their specific assignments and of their attempts to influence the development of other professional nurses. Other representatives might have selected different examples of the interpretation of professional responsibilities of the nurse at varying levels of the professional ladder, but it is very likely that the concepts behind their interpretation would have been quite similar. They have attempted to illustrate the methods utilized within the Nursing Department by which professional nurses may progress to levels of increasing responsibility (1) for influencing the quality of nursing care to the patient and nursing support of clinical research, and (2) for making an impact upon the nursing community.

One can readily recognize common facets for fulfilling each of the roles portrayed. Expanding expertise in the knowledge and skills required in each area of specialty, of course, takes a position of importance. Exercise of judgmental, decision-making, and priority-setting abilities are necessary at each level of responsibility, with greater sophistication expected as the nurse progresses toward more independence in functioning. On-going evaluation, ranging from evaluation by others to self-evaluation, and an ever-growing appreciation for the potential contribution to the overall goals of the department were inherent also in the roles described. Most significant in their discussions was a pervasive attitude—an attitude that the efforts expended were not directed toward personal status, but rather toward the achievement of quality nursing performance and the continuous development of professional goals.

In conclusion, the concepts upon which the career ladders for professional progression within the Clinical Center Nursing Department are based have been described, and examples of their application have been given. However, it is recognized that the realization of the goals for professional development cannot be achieved *for* the individual simply because the administration has enunciated them. Nor can they be achieved solely upon exposure to exemplary role-models. The individual, herself, has to formulate her own profes-

sional goals and take advantage of the developmental opportunities available to her. When the nurse has achieved that level of maturity, she will have made a significant stride toward professionalism in nursing.

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